

Lived Experiences of Mothers with Postpartum Depression in Rural Tanzania

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Abstract Introduction: Postpartum depression affects 15-20% of mothers globally, yet remains under-researched in low-resource settings like rural Tanzania, where maternal health efforts prioritize physical over mental well-being. Cultural stigma, limited healthcare access, and socioeconomic hardships aggravate PPD, yet women's lived experiences are rarely documented. This study aimed to explore the narratives of mothers with PPD in southern Tanzania to uncover the challenges, coping mechanisms, and unmet needs, which are crucial in informing tailored interventions and policies. Methods: A qualitative approach was used, involving ten semi-structured in-depth interviews with purposively selected mothers of infants less than 24 weeks, scoring ≥ 26 on the Edinburgh Postnatal Depression Scale, indicating severe depression. The study explored the lived experiences, community interactions, and perceived drivers of mental health disorders in this context. Results: Four major themes emerged: Parenting while dealing with depression, including difficulties bonding with the baby, suicidal thoughts, attempts, and consideration of harming or abandoning the baby; Factors that trigger depression episodes, such as lack of support, difficult livelihoods, early marriage, unplanned pregnancies, difficult pregnancies and deliveries, and domestic violence; Coping mechanisms include primary confiding in trusted friends; and Recommendations for services and support systems including awareness campaigns, strengthening healthcare capacity, providing targeted support, and involving both the government and community structures. Conclusion: Findings highlight a critical gap in awareness and support for PPD among women in low-income settings. Despite enduring profound sadness, alarming thoughts, and challenging circumstances, many women lacked knowledge that PPD is a health condition, reflecting broader societal neglect and stigma surrounding mental health. Addressing these gaps requires urgent efforts to raise awareness, ensure accessible interventions, and foster supportive environments within families and communities.

Keywords: Postpartum depression, Lived experiences, Rural Tanzania, Maternal mental health, Mental health support

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1. Introduction

Postpartum depression (PPD), also known as postnatal depression (PND), is a type of clinical depression that affects women within the first year following childbirth and poses a significant public health concern [1]. Globally, PPD is estimated to affect 15% to 20% of mothers, resulting in approximately 600,000 to 800,000 cases annually [2]. This condition presents significant challenges for new mothers who must juggle

responsibilities for their newborns, older children, and work outside the home [1]. Screening and diagnosing PPD helps identify mothers who need support [3]. One common tool used is the Edinburgh Postnatal Depression Scale (EPDS), which is a brief questionnaire consisting of 10 questions [3]. It is user-friendly and functions effectively in both clinic and community settings, even in areas with limited resources [4]. A score of 13 or more indicates that a mother may be experiencing depression, while scores of 26 or higher reflect severe symptoms requiring urgent attention. In this study, the EPDS was employed to screen mothers at postnatal clinics, and those

scoring 26 or above were selected for interviews. Utilizing such tools during postnatal visits helps identify mothers who are struggling and provides them with the opportunity to receive help promptly. PPD impacts mothers' psychological health, quality of life, and interactions with family members, including their infants, partners, and relatives [5]. A systematic review of seventeen studies from developing countries reveals a significant association between maternal depression and child growth, with many children of depressed mothers being underweight and stunted [6]. PPD is also linked to adverse psychological outcomes in children up to 10 years old, particularly in low- and middle-income countries, causing distress for both mothers and their children [3,5,6]. Globally, PPD is a significant public health concern affecting about 17% of mothers, though prevalence varies considerably by region due to differences in healthcare access, socioeconomic conditions, and cultural contexts [3]. In Sub-Saharan Africa (SSA), the prevalence of PPD is approximately 18.3%, driven by limited mental health services, high maternal morbidity, and socioeconomic stressors [4]. However, prevalence varies notably across SSA countries: South Africa has among the highest rates at around 30.6%, with rural areas reporting even higher rates above 50% [7]; Zimbabwe reports a prevalence of 29.3% [8]; Ethiopia and Nigeria have rates of about 22% and 16.8%, respectively [9], and Tanzania has relatively lower rates ranging between 8.8% and 20.5%, with a pooled average of about 13.5% [8,10]. This variation can be attributed to differences in study settings, with urban areas often having different rates compared to rural regions due to disparities in healthcare access and services [8]. Important risk factors in Tanzania include younger age, low socioeconomic status, parity, marital status, unplanned pregnancies, and inadequate family and partner support [11,12]. For example, a study in Dar es Salaam revealed that 44% of adolescent mothers experienced PPD, largely linked to being unmarried, lacking family support, and financial difficulties [12].

Tanzania and many other low and middle-income countries (LMICs) have a critical gap in research that quantifies PPD prevalence, identifies risk factors, public awareness, perceptions, and assesses the need for and accessibility of mental health services for new mothers [13]. Due to a lack of resources and trained personnel, mental health care services at the primary level are often limited, and public understanding of mental health remains poor [14]. In Tanzania, antenatal care and safe delivery programs have significantly reduced maternal mortality, while the emotional and psychological well-being of mothers has received little attention [14]. The Ministry of Health and its partners in Tanzania have focused primarily on reducing maternal and infant mortality, with insufficient emphasis on mothers' emotional and psychological health [14,15]. As a result, PPD cases go unnoticed and untreated, falling short of WHO's definition of health [14,15]. However, the experiences of these mothers and how they cope with PPD remain largely unknown. Understanding PPD from a mother's perspective is crucial for designing effective policies and interventions [8]. This study explored the lived experiences of mothers with young children under 24 weeks who had been diagnosed with PPD. These

mothers were attending postnatal clinics at St. Francis Referral Hospital (SFRH) and Kibaoni District Hospital (KDH) in the Kilombero Valley in southern Tanzania. Notably, this study will contribute to the achievement of the Sustainable Development Goals (SDGs), the Africa We Want (Agenda 2063), and Tanzania's Vision 2025 by addressing critical gaps in maternal mental health, gender equality, and rural healthcare access. It supports SDG 3 (Good Health and Well-being) and SDG 5 (Gender Equality) by advocating for improved mental healthcare for postpartum women, reducing disparities faced by rural mothers [10]. The research aligns with Africa's Agenda 2063 by promoting healthy citizens and inclusive development [16], while also advancing Tanzania's Vision 2025 goals of reducing maternal mortality and enhancing quality of life through equitable healthcare [17]. By amplifying the voices of marginalized mothers, the study provides evidence for policymakers to strengthen mental health services, ensuring no woman is left behind in national and global development efforts.

2. Methods

2.1. Study Site

The study was conducted in the Kilombero Valley in southern Tanzania (Figure 1). The Valley comprises four councils: Malinyi, Mlimba, Ulanga District Council, and Ifakara Town Council. This research was carried out within the Ifakara town council (ITC), which is primarily served by St. Francis Referral Hospital (SFRH) and Kibaoni District Hospital (KDH). These two hospitals provide services to clients from all four councils and offer comprehensive maternal and childcare services. The major economic activities in the Kilombero Valley include agriculture, particularly subsistence rice farming, as well as livestock keeping, fishing, and entrepreneurship. The detailed description of the study site can be found in the sources [7,9,18].

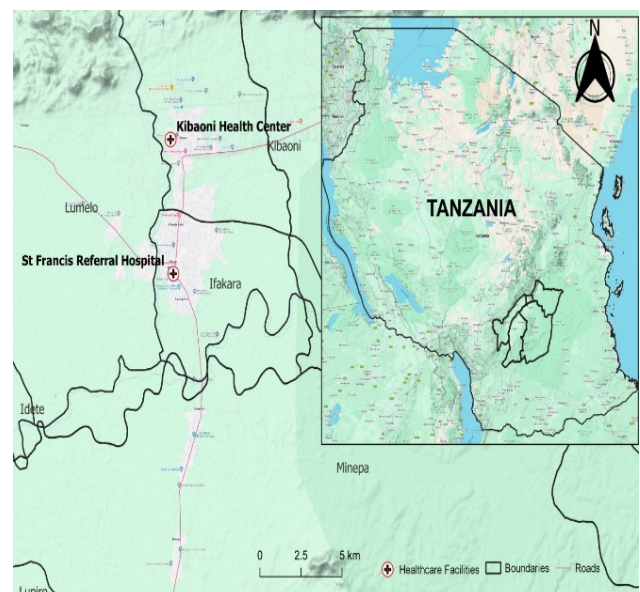


Figure 1. A map showing healthcare facilities from which the mothers were recruited for the in-depth interviews

2.2. Study Procedure

This study was a component of a large study that explored the prevalence and risk factors of PPD in southern Tanzania [9]. This particular component was a qualitative study that employed semi-structured in-depth interviews (IDIs) with mothers diagnosed with PPD [7]. The IDIs were conducted with all the mothers who scored 26 and above on the EPDS, and ten were purposively selected to participate in the IDIs [18]. Eligible participants had children aged 24 weeks or younger. The interviews explored four key themes: (i) mothers' perceptions of their mental health and its impact on their own and their children's lives, (ii) daily life experiences while managing depression, (iii) factors contributing to their feelings of depression, and (iv) recommendations for essential services and support systems to improve their well-being and that of their children. The IDIs, conducted in 2018 at the postnatal clinics of the two hospitals, lasted between 45 and 60 minutes. To ensure accuracy in data collection and analysis, audio recordings were made, and detailed notes were taken during the interviews. GJM, FK, KK, and MFF facilitated the discussions. FK and KK transcribed the audio and translated the verbatim from Swahili to English.

3. Data Analysis

All the recorded data were transcribed into verbatim reports and cross-checked against the audio recordings to ensure accuracy. The transcripts were then thoroughly reviewed, translated into English, and re-checked by the authors to minimize the risk of misinterpretation. The data was then imported into NVivo software version 12 [19] for further in-depth analysis. Thematic content analysis was done [23]. Both inductive and deductive coding were used. The IDI guide was used to develop deductive codes, and inductive codes were generated through a thorough review of the transcripts. Recurrent themes were extracted from the emergent patterns, and direct quotes from the participants were used to underscore the thematic findings.

4. Results

The current study was a follow-up to the first study conducted in the Kilombero Valley between 2018 and 2020, which assessed PPD among 601 mothers and found a prevalence rate of 8.8% [9]. From this larger quantitative study, 10 mothers with an EPDS score of 26 and above were purposively selected for a qualitative study. These participants took part in in-depth interviews aimed at exploring their personal experiences and challenges related to living with PPD. Ten mothers participated in the study, as indicated below in Table 1. The mothers had a mean age of 29.2 years, ranging from 18 to 38 years. The mothers had an average of three children, ranging from one to five children per woman. Two of the mothers had no formal education, three had completed primary school, and three had completed secondary school. Eight out of ten mothers were unemployed, and five were married. Of those employed, one was a teacher, and one was working

in a cleaning company. For those who were unemployed, two were stay-at-home moms with no particular activities, and six participated in various activities such as selling vegetables in their communities, farming, cooking food at the bus stands, washing clothes, and cleaning people's houses.

Table 1. Characteristics of the study participants (n = 10)

Variables	Frequency
Age group	
18-20	2
21-29	2
30-38	6
Mean age (years)	29.2
Marital status	
Married	5
Unmarried	5
Level of education	
No education	2
Primary school	3
Secondary school	3
Tertiary level/College	2
Employment status	
Employed	2
Unemployed	8
Number of children	
One	2
Two	4
Three	1
Four	1
Five	2

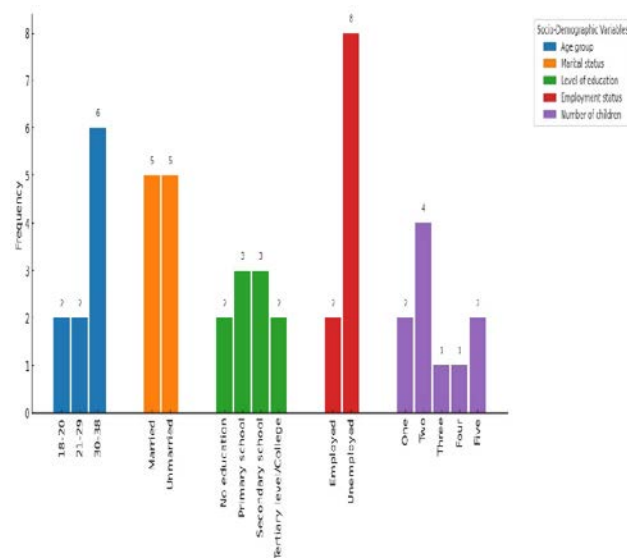


Figure 2. Socio-demographic characteristics of the study participants

4.1. Experiences of Living with PPD

Concerning the mothers' lived experiences with PPD, four major themes were identified. These included: i) Experiences with parenting while dealing with the depression, ii) Factors that trigger the depression episodes, iii) Coping mechanisms, and iv) Recommendations on necessary services and support systems to enhance their own and their children's quality of life. These themes are described in detail below.

4.1.1. Parenting with Depression

All mothers expressed challenges in forming close attachments with their babies. Many cited a lack of support as a primary obstacle, making it difficult to maintain consistent feeding and caregiving routines while managing responsibilities for the rest of the family. The absence of support and empathy left them feeling neglected, occasionally resulting in lapses in attention towards their children. Despite these difficulties, a majority of mothers shared that they found strength for their children, often drawing support from friends, neighbors, and their resilience. Here is what two of the mothers said:

"Sometimes I get so overwhelmed that I just cannot do anything at home, so I just sleep. Then I worry too much, what will my children eat? Will I make enough? My neighbors help, they give me food or money sometimes, and sometimes they can come and wake me up when I do not feel like it. I try not to think of him [partner], as it doesn't help. My 4-year-old asks often, which makes me even sadder. But I must go on for my children." (30 years)

"I often wonder what will happen to my babies if I die. I pray and encourage myself. I have talked to my friend about it, and she told me not to think of things like that. God helps me." (30 years)

Two mothers bravely shared their harrowing experiences of reaching such overwhelming depths that they attempted suicide. One mother recounted her deep despair upon discovering both she and her husband were living with HIV. The devastation deepened when her husband abandoned her upon learning of the news. At times when she got too ill, she struggled to end her life, yet tragically, this did not reunite her with her husband. Here is what she said:

"There was a point where I was so ill that I attempted suicide. I took poison, but I did not die. Still, he never supported me materially or even emotionally. The worst thing of all is that at 8 months of pregnancy, he started working again and ignored me even more than before. When I went into labor, I told him, but he paid no attention. So, I went out and found transport on my own, I got a bodaboda [motorcycle-taxi] that took me to the hospital in the middle of the night." (36 years)

One mother recounted how her partner refused to support her during her struggles. Overwhelmed with anger and despair, she reached a breaking point where she attempted to take her own life. Fortunately, her neighbor intervened just in time, offering crucial support and encouragement that helped her reconsider her decision. This is what she said:

"Sometimes when I asked him too much, he would get angry and threaten me. So, one day I got so angry and I sinned. I pray that God forgives me for that. I decided to commit suicide because I was struggling too much. It was just too much torture, and I did not have any friends or relatives or anyone to help me. But luckily, one lady came; she was my neighbor. She saw what I was about to do, and she encouraged me not to do it. She said if I kill myself, even my other child back home would suffer, and there would be no one to take care of her. My parents are very old; they cannot support her for long. So, I listened to this lady and changed my mind." (35 years)

Amid overwhelming stress and isolation, a mother

bravely disclosed experiencing moments when she felt compelled to harm her baby, even attempting to poison the infant at one point. She attributed these distressing actions to the overwhelming responsibility of caring for her child without any support. She explained that she lacked assistance in caring for the infant and struggled without adequate food or other necessities. To provide for her family, she attempted to sell vegetables in the village while balancing the care of her baby, but found the task too challenging to manage alone. Here is what she said:

"Yes, last month I wanted to poison myself and the baby because of too much suffering. Talking to friends and making stories helped; they told me it is life; I should just raise my child, a day will come, it will all be well, and I listened to what they told me." (18 years)

Faced with financial hardship, a mother tearfully recounted having to leave her child at his father's home on several occasions. Despite her tireless efforts to sell charcoal and vegetables in the village, she struggled to earn enough to provide for both herself and her baby. This is what she said:

"So, I gave him his child and left. I told him that if he thinks five thousand [~2 USD] is enough to provide food for two people for a whole week, then he should try it with his child. So, I left the baby there with him. I left them all there. They stayed there thinking that I would come back, but I had made up my mind, I did not want that child, he was causing me too much trouble." (35 years)

4.1.2. Factors that Trigger Depression Episodes

Lack of support: Lack of support was expressed as a major trigger for depression among the mothers, in the form of social, financial, and physical support. In terms of social support, the mothers explained that they often lacked quality time with their close family or the fathers of their babies, which often made them feel lonely and sad, as expressed by this mother. In this regard, one mother spoke of the situation with her husband:

"Ever since he got the job in big cars, my husband has had no time for me. Even when I try to follow him, he still does not give me time. Calling him equals disturbing him, he never picks up my calls. Sometimes he blacklists so I can't reach him." (36 years)

In terms of physical support, the mothers elaborated that having an infant often added more burden to their already demanding lives. Due to difficult livelihood, the mothers were unable to hire extra help and were therefore forced to continue with their daily chores, such as cooking for the family, washing, cleaning, and sometimes vending vegetables. Participants explained that these chores often left them feeling exhausted, sad, and worthless, as this mother explained:

"It was very painful when I returned to my home. I had to do everything on my own. There were other people, and I would see them passing around, but they never brought anything to help." (36 years)

Some of the mothers also reported that they mostly depended on their partners for financial support, but they were often left disappointed as the fathers did not provide such support. Some of the mothers said that they would often try to sell vegetables in the village, taking them from house to house, but often this did not help much as there were often plenty of other merchants that were also doing

the same, as this mother elaborated:

"Business is hard, I sell vegetables all day with my child at the back. Some days you come back home with only 1000 shillings [<1 USD]" (18 years)

"Most of the women around here sell vegetables, we go from house to house, and this becomes a competition" (20 years)

Some of the mothers further elaborated that they sometimes reached out to their own families to ask for help, but this was also often in vain due to difficult livelihoods all around, and sometimes, a lack of caring, as this mother said:

"What hurts me even deeper is my father works here at this hospital. Yes, he is a gateman and ever since he retired, I have never received even 100 shillings from him; he looks at me like feces." (32 years)

When asked about how they dealt with the lack of support, the mothers listed various efforts, including talking to their partners' friends and family, and reporting their partners to the authorities and village leaders. However, the mothers explained that often these efforts were in vain as they seldom helped to alleviate their pain, as these mothers explained:

"Yesterday I went to the police station and they told me to come here and seek the social support service for my husband, says the child is not his and therefore provides no child support, his relatives are the ones who sometimes help, like buying clothes, himself wants to hear nothing about this child, not even when the child is ill." (36 years)

"In the evening, I called his friend that I know, and I told him everything that I had gone through with this man. The friend encouraged me to stay strong and took me to see my father. So, we went together, and when I saw him, he said he did not have any money, and he had a lot of debts. He started shouting at me, saying that I was always bringing problems to him, that he was tired of me and my problems. So, I just said okay. He kept saying that other women would be grateful to get 5 thousand shillings per week, and it would be enough, but for me, I was always complaining." (35 years)

Difficult livelihoods: The major factor discussed here was financial difficulties, which were said to be exacerbated by lack of support from partners, family, or friends, unemployment, and large family size. A majority of the mothers, even those with working partners, explained that they faced financial difficulties, which contributed to their feelings of depression. These mothers explained their heartbreaking experiences:

"Life is hard. My husband sells vegetables; he takes them around people's houses. He does that all day long. On a good day, he can make a profit of 3000 [~1 USD], we use that to get food and other needs, and he uses 5000 [~2 USD] as capital." (32 years)

"We would work in the rice field all day. We did not have much food, we used to have mangoes and porridge for lunch. On a good day, my husband would get 2000 shillings [<1 USD] for food, but it was never enough." (32 years)

In her account, a mother bravely shared her struggles, revealing that during her pregnancy, she was burdened with substantial debt and lacked any source of income to support herself and her other children. These overwhelming financial pressures led her to contemplate

suicide, as she explains here:

"When I was pregnant, there were times life had gotten so difficult that I wished to terminate it, but I had a change of heart and did not do it. I had several debts and bills to pay, and I did not have any income." (30 years)

Early marriage: One of the mothers reported that when she was sixteen, her mother forcefully married her off to an elderly man in exchange for money. She had to move from her home to another village against her will, where she was forced to work on the rice farm on top of fulfilling her marriage obligations. After two years, by which time she was pregnant, she managed to leave her husband due to both physical and emotional abuse and moved back to her childhood home, but the abuse continued. Here is what she said:

"About two years ago, when I completed primary school, we went to the fields to prepare the farms for planting seasons, but my mother took money from a Sukuma man and married me off, just like that. I never liked the guy or the idea of marriage, so the whole thing was very difficult for me to accept. I was forcefully left with the man, and I did not know my way home, so I had to live with him. I reported the matter to the village chairman and my uncles, but they told me they could not help me" (18 years)

Unplanned pregnancy: Four mothers said that they regretted getting pregnant, but they were not aware of family planning methods, which led them to have unplanned pregnancies, with some having these multiple times. They reported that they felt unprepared to have the babies, and adding to the difficulties livelihood and lack of support from their spouses and families led to their feelings of depression. One mother said that she felt even worse when her family blamed her for the pregnancy. Here are the experiences as told by two of the mothers:

"I thought of having an abortion. I thought of it and told my husband, but he said we should keep the pregnancy because those are God's plans, and I might die in the process. Should be patient, he survived without parents, so will the two of us." (32 years)

"They did scold and abuse me in some ways, like they would ask why I carried the second pregnancy while I already had the first. I am doing it on purpose." (30 years)

Difficult pregnancies and deliveries; Four out of the ten mothers reported experiencing challenging pregnancies, while three said that they had traumatic childbirth experiences that overshadowed the joy of welcoming their babies. Among those who had difficult pregnancies, all described frequent illness during gestation, leading to heightened anxiety and fear for their own lives and the well-being of their unborn children. Two mothers shared their experiences:

"Well, I had high blood pressure, so it was hard. My whole body was very swollen, and I felt bad most of the time. It started seven months into the pregnancy. At the clinic, a nurse told me that my pressure was high, and she gave me green pills to take. So, I was taking those, and they helped. But it was always hard. When my father started insulting me, I would get sick again. My body started swelling when I was 8 months pregnant." (35 years)

"I had heart problems five months through the pregnancy. I would get dizzy often, and sometimes I would lose consciousness. At the clinic, they told me to stop

overthinking, drink lots of water, and get enough rest, and that all would be well, but it was not.” (38 years)

Regarding the mothers who faced challenging deliveries, all recounted giving birth via cesarean section as a painful and costly experience that intensified their fears for their own lives and the well-being of their babies. One mother recounts her experience:

“In the beginning, I was frustrated because I had my first child through an operation and was told to wait three years to have another pregnancy. So, I was worried that my first child is not yet three, I had him in September 2015, and this one is here in April this year, so three years is not yet.” (29 years)

Domestic violence: Seven out of the ten mothers disclosed enduring domestic violence throughout their pregnancies and into the postpartum period. They suffered verbal, sexual, and physical abuse inflicted by their spouses and other family members. The verbal abuse ranged from threats of physical harm, including beatings and stabbings, to enduring derogatory and hurtful names. The mothers said these often made them feel worthless, and some attempted to commit suicide. These women shared their experiences while crying:

“I have messages from him [husband], I have always saved them. He would insult and threaten me. So, it just continued like that until I went home and gave birth. By the time I gave birth, he had already told me that he had a wife and I should not disturb him. So, by then, even if I asked him to give me money to buy cooking oil, soap, or baby oil, he would refuse, and many times he would just insult me. He makes me feel very bad, and many times he makes me want to do that bad thing again.” (35 years)

“My mother has been threatening me ever since I was young. When I was fourteen, she used to threaten that she would kill or slaughter me if I did not pass my exam. She threatened me like this a lot. Throughout my life, she has always used foul language to me. When I returned home from my husband’s house, the verbal abuse continued, so I moved out and rented a room. She still comes to ask for money, and when I do not have it, she continues to verbally abuse me.” (18 years)

The four mothers who bravely shared their experiences of enduring physical beatings from their spouses and family members said that the experience left them with lasting scars, both physical and emotional, impacting their sense of safety and well-being. Here are some of their harrowing experiences:

“He [partner] scared me a lot. He could change at any time, and he would end the relationship so often, but then come back. When I tried to find another partner, he would get very angry. He once locked me up, beat me, and threatened to stab me. I don’t know what I have done wrong, because he is always the one who leaves me.” (36 years)

“When I was with my in-laws, they treated me like a slave, wanted me to always work on the farm, or to cut grass for the cows. My husband beat me up three times. He used to carry loads at the mill, but he would never leave money for food. I reported him to the village leader, and later on to the police, but nothing happened; he continues to threaten me.” (30 years)

“My mother used to beat me up a lot. She would use anything to hit me; sometimes she used her fist or a ladle. It could be for any small mistake. Two weeks after I gave

birth, she beat me because I asked a neighbor’s child to help carry the baby while I washed up. She kicked me out of the house a month after I had my child.” (18 years)

4.1.3. Coping Strategies that Mothers Used

A majority (eight) of the mothers said that they tried to talk to close friends when they felt very sad, when they felt like running away, or when they had feelings of harming themselves or their babies. None of the mothers mentioned family members as their source of support. Others said they tried to persevere, hoping that things would get better. Here are the experiences as told by some of the mothers:

“I get help from my friends. Talking to them and telling stories helps take my mind away from everything else that is going on. There are some women who I live with near my compound, they encourage me a lot. They tell me life is like this, I should be tough, just raise my child, and that one day it will all be well.” (20 years)

“A lady friend of mine had a feeling I was planning an abortion, so she cautioned me against it early on. She told me that this child could become my savior later in life. She used to call me often, which helped a lot.” (36 years)

4.1.4. Mothers’ Recommendations

Most of the mothers admitted that they were unaware of or did not fully understand postpartum depression. They recommended raising community awareness and enhancing the capacity of healthcare workers, especially those dealing with maternity issues, to identify and manage the condition effectively. They also emphasized the importance of making available targeted support and resources tailored to the unique challenges they face in their communities. Here is what was suggested;

“I think mostly education and raising awareness of this problem, and I think it should be done even before one decides to get pregnant.” (29 years)

“Depression? I think I heard it once. I don’t know how it happens, but maybe due to lots of thoughts or stress, it can cause it. The government should help us with this, no one is aware of this problem in our communities. Most people think it has to do with witchcraft or poor relationships only.” (18 years)

“I think the doctors know better, they should be able to tell when a mother is depressed and what kind of help can be provided” (38 years)

5. Discussion

To our knowledge, this is the first study that has explored the lived experiences of mothers with PPD in Tanzania, and possibly sub-Saharan Africa. Mothers reported issues related to parenting while dealing with depression, factors that trigger the depression episodes, coping mechanisms, and recommendations on necessary services and support systems to enhance their own and their children’s quality of life.

The finding that mothers struggled to form close attachments with their infants due to insufficient support aligns with numerous studies conducted in low-resource and high-stress postnatal contexts. As noted from Australia, mothers with limited social support reported

higher levels of emotional distress, which hindered the natural development of strong maternal-infant bonds [20]. Similarly, in the United States, it is observed that the lack of consistent support diminished mothers' confidence and disrupted caregiving routines [21]. However, those who were able to draw on community networks, such as friends and neighbors, demonstrated greater resilience and adaptability in caregiving roles. In support of this, a systematic review from developing countries found that social support significantly enhances maternal responsiveness and emotional availability, both of which are essential for healthy attachment formation [6]. Within the Tanzanian context, it highlighted how inadequate support from partners and extended family intensified symptoms of PPD, often resulting in emotional withdrawal or occasional neglect of children [22]. Nonetheless, contrasting evidence exists. For instance, while social support does positively influence bonding, some mothers in the United States were able to maintain strong attachments with their infants despite limited external support, primarily due to personal coping strategies and inner resilience [23].

Similar findings of struggle with PPD while living with HIV infections have been reported in multiple studies. In Kenya, women with PPD frequently reported feelings of hopelessness and suicidal thoughts, especially when faced with chronic illness (such as HIV), poverty, and marital conflict [24]. Another study in Tanzania highlighted the high burden of depression among mothers living with HIV infections and how HIV diagnosis compounded feelings of worthlessness and despair, and in some cases, led to suicidal ideation, particularly when family or partner support was absent [22]. Additionally, a study in rural South Africa emphasized that suicidal ideation in postpartum women exists; its intensity and outcomes are often shaped by factors such as health status (e.g., HIV), partner support, and access to mental health care [25].

Lack of support has profoundly impacted the mental well-being of mothers across social, physical, and financial dimensions. These experiences are consistent with findings from different studies, which identify inadequate social support as a key contributor to PPD and maternal distress [23,24,25,26,27]. For instance, research from Portugal, China, and the United States emphasizes the significant role that financial instability plays in exacerbating maternal depression, reinforcing the link between economic hardships and deteriorating mental health [28,29]. Qualitative evidence from Canada, Gambia, and Uganda underscores the emotional toll of insufficient social support. Many mothers in these settings describe feeling let down by well-meaning yet unhelpful advice, or even facing criticism from family and friends, which deepens their sense of isolation and emotional burden [24,25,26,27]. A meta-analysis of 84 studies from the 1990s found that inadequate social support from partners, family, and friends is strongly associated with higher rates of PPD [30].

Financial hardship and physical exhaustion also intensified depressive symptoms. For example, in Dar es Salaam, Tanzania, it is argued that in low-resource settings, lack of financial support triggers maternal depression [22]. In South Africa, emotional neglect was similarly linked to experiences of loneliness and sadness

[31]. Furthermore, these findings align with the study in the United States, which found that even when family was physically present, the absence of adequate emotional and practical support contributed to feelings of sadness and depression [32].

The findings of the impacts of financial hardship on maternal mental well-being align with several qualitative studies, which have also found that financial difficulties are a major factor contributing to PPD. For example, a systematic review conducted in India identified financial difficulties, lack of spousal support, and marital conflict as key risk factors contributing to the onset of PPD [33]. In Iran, a study involving healthcare professionals revealed that poverty and unemployment were major stressors leading to maternal emotional breakdowns, often due to insufficient income affecting basic needs such as nutrition and healthcare access during pregnancy [34]. Another study in Iran found that low socioeconomic status heightened emotional distress during and after pregnancy, making women facing economic challenges report disrupted living conditions and perceived pregnancy as a burden rather than a joyful event, further worsening depressive symptoms [35].

The related studies link early marriage, especially forced marriage and associated abuse, to increased risk of PPD. A systematic review of papers published between 2000 – 2020, for instance, in Ethiopia, found that women married young often face physical and emotional abuse, loss of autonomy, and heavy labor demands, which contribute to psychological distress and depression after childbirth [36,37]. In Turkey, forced relocation and lack of support intensify feelings of isolation and vulnerability, increasing PPD risk [38]. These experiences align with findings from the United States and India that traumatic life events, lack of social support, and marital conflict are significant contributors to PPD in mothers [32,33]. Furthermore, in Iran, early marriage coupled with experiences of abuse and socioeconomic adversity significantly compromises women's psychological health, personal autonomy, and emotional stability throughout pregnancy and the postpartum period [35].

Unplanned pregnancy is strongly associated with increased risk of PPD and antenatal depression. Findings from other studies in Iran have also reported that the emotional burden of unplanned pregnancy is caused by social blame and inadequate family planning knowledge, increasing feelings of isolation and depression [34,35]. In Ethiopia, it is reported that lack of social support and financial difficulties further worsen the risk of PPD in women with unplanned pregnancies [39]. A longitudinal cohort study from the Netherlands indicates that women with unplanned pregnancies have persistently higher depressive symptoms during pregnancy and up to 12 months postpartum compared to those with planned pregnancies [40].

This study consistently reports that difficult pregnancies and traumatic deliveries are significant risk factors for PPD. Women in Iran and Sweden experiencing frequent illness or complications during pregnancy often face heightened anxiety and fear for their own and their unborn child's health, which contributes to psychological distress and PPD symptoms [35,41]. A review and a study show that traumatic childbirth experiences can lead to anxiety,

panic attacks, and symptoms resembling post-traumatic stress disorder (PTSD), further deepening depressive states post-delivery [42,43]. Studies from both the United States and India report that the lack of adequate social and healthcare support during and after these challenging experiences intensifies emotional distress and feelings of isolation among mothers [32,33].

There is a direct relationship between domestic violence (DV) and PPD. This is supported by Qualitative and systematic reviews from Ethiopia and Turkey, respectively, showing women experiencing verbal, physical, and sexual abuse during pregnancy and postpartum report feelings of worthlessness, constant fear, and increased risk of suicidal ideation [37,38]. Psychological abuse is the most prevalent and strongly linked form of DV contributing to PPD. A systematic review among Asian women highlights that violence from intimate partners and other family members raises the likelihood of PPD by 1.6 to 7 times [44].

In this study, the majority of mothers reported relying on close friends as their primary source of emotional and spiritual support. Interestingly, family members were not mentioned as part of the support system. Others described perseverance and expressed hope that circumstances would eventually improve. These findings align with existing literature in the United States, indicating that mothers with PPD often use emotion-focused coping strategies such as talking to trusted friends to share their feelings and reduce stress, especially when experiencing thoughts of self-harm or overwhelming sadness [45,46]. A meta-analysis shows that perseverance and the hope that circumstances will improve are also common coping mechanisms [47]. In the United States, spiritual or religious practices frequently serve as important sources of strength and resilience [45]. However, similar to this study, Columbia has shown that family members are not always considered reliable sources of support, and many mothers instead turn to close friends or peers for comfort [48]. In China, coping strategies vary more widely, with some mothers choosing to hire domestic help to ease their burdens. In contrast, others resort to doing nothing due to emotional paralysis or stigma surrounding mental illness [49].

Mothers with PPD commonly recommend raising community awareness about PPD [50,51] and enhancing healthcare workers' capacity to identify and manage it effectively, especially those involved in maternity care [1,45,52]. They emphasize the need for targeted support and resources tailored to their specific community challenges, highlighting gaps in knowledge and support availability [47,52,53]. Studies show that mothers often lack understanding of PPD and call for education programs for both families and healthcare providers to improve early detection and intervention [50,52]. Additionally, mothers suggest that healthcare services should allocate sufficient time and resources to provide counseling, education, and emotional support to parents experiencing PPD, which can improve outcomes for both mothers and infants [48,54].

6. Limitations of the Study

This study has several limitations that should be acknowledged. The small sample size of ten low-income women from a rural area limits how well the findings can be applied to other groups, such as urban or higher-income mothers. Only mothers with severe depression (EPDS ≥ 26) were included, excluding those with milder symptoms. The study relied on self-reported data, which may be affected by the probability of recall bias, and the researchers could not verify personal or medical claims. These factors limit the generalizability of the results beyond the study setting. Nevertheless, this study is one of the few to explore the real-life experiences of mothers with severe PPD in rural Tanzania. Using in-depth interviews and a validated screening tool (EPDS) to give voice to a vulnerable group in low-resource settings that can help improve maternal mental health efforts and inform future research.

7. Conclusion and Recommendations

7.1. Conclusion

This study shows the urgent need for strong support systems for mothers with PPD, especially in rural areas where resources are limited and isolation is common. Many mothers rely on friends and neighbors for help, showing a lack of formal mental health support. A majority of situations that likely resulted in depression, such as forced marriage, unplanned pregnancies, and domestic violence, are highly preventable if enough attention is directed to them. There are several services in the communities, such as departments of social services, the police, and faith-based institutions, where women can access these services. However, awareness of these is relatively low among both the mothers and the communities (Rajab-Kadiri et al, unpublished).

7.2. Recommendations

The findings of this study reveal that multiple interrelated factors drive PPD among rural Tanzanian mothers. To address these challenges, community-based interventions are essential. These include establishing mother-to-mother support groups and peer counseling networks to strengthen emotional and social support; integrating PPD screening and counseling into routine maternal and child health services at local clinics; engaging men and community leaders in awareness and gender-sensitization campaigns to combat stigma and domestic violence; linking vulnerable mothers with existing community-based income-generating programs to reduce economic stress; and enhancing family planning education and services to prevent unplanned pregnancies. Additionally, capacity building for community health workers and healthcare providers in early identification and management of PPD, coupled with public education through radio programs, faith-based organizations, and

village meetings, would foster supportive environments and promote early help-seeking among affected mothers. Lastly, this study recommends a further, more detailed assessment of PPD across the country.

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